Giving to the
Morehead Memorial Hospital Foundation

Donor Information

Preferred Title (circle one) Dr. Mr. Mrs. Ms. Miss Other _____

First Name _____ Middle Initial _____

Last Name _____

If your gift is a company or corporate gift, please complete the following section. If not, skip to Address.

Company Information

Company _____

Contact Person _____

Title _____

Address Information

Address _____

_____

City _____

State/Province _____

Zip/Postal Code _____ Country _____

Daytime Phone _____ – _____ – _____

E-Mail Address _____

Gift Amount

I would like to make a gift of (circle one) $1000 $500 $350 $100 $50 $25 Other _____

Donations of $500 or more are listed in our annual report.

Method of Payment

I have enclosed a check in the amount of $ _____

Please make check payable to **Morehead Memorial Hospital Foundation.**

Mastercard Visa Discover

Card Number _____ Exp. Date _____

Name on Card _____

Signature _____

Designation Options

I would like my/our contribution to benefit (check one)

The hospital's most pressing needs

The Good Samaritan Project Fund

Building needs

Clinical service area (you may specify):_____

The Smith McMichael Cancer Center

The Morehead Memorial Hospital Nursing Center

Scholarships [select from options below]

___General

___Endowment scholarship for nursing

___endowment Scholarship from Auxiliary

Other _____

If no designation is selected, your gift will be applied to the hospital's most pressing needs. For a partial listing of hospital funds please check our website under "Foundation" on the page labeled "How to donate and help others" on this Web site or call the Foundation office at 336-627-6334.

Recognition Preference

Please list my/our name in donor recognition material as:

_____

I/we would like this gift to remain anonymous.

Honor / Memorial Giving *(optional)*

Select one

I would like to dedicate my gift in **memory** of _____, my

I would like to dedicate my gift in **honor** of _____, my

Wife Sister Aunt

Husband Brother Uncle

Mother Grandmother Cousin

Father Grandfather Friend

Colleague Physician Other _____

For the special occasion of _____

(birthday, anniversary, etc.)

Please notify

The amount of the gift will not be disclosed.

Preferred Title (circle one) Dr. Mr. Mrs. Ms. Miss Other _____

First Name _____ Middle Initial _____

Last Name _____

Address _____

_____

City _____

State/Province _____

Zip/Postal Code _____ Country _____

How would you like to be referred to in the notification letter

_____

Signature _____

I would also like information about the Casten-Dixon-Tyner Legacy Society by:

☐ **Including the hospital in my will**

☐ **creating a Charitable Gift Annuity with the Foundation**

Please sign and mail this completed donation form to:

Morehead Memorial Hospital Foundation
117 East Kings Highway
Eden, NC 27288

or fax to: 336-623-1570